

**State Required Annual Program Data
For
County Medical Therapy Programs**

Fiscal Year ____/____

TO BE COMPLETED BY COUNTY CCS PROGRAM

County _____

Date ____/____/____

- 1) Total No. of MTUs in County _____ 2) Total No. of MTU-Satellites in County _____
- 3) Total No. of Children on MTP Caseload _____ 4) Total No. of Children with IEPs _____
- 5) Prescribed Hours Per Week of Physical Therapy _____ Occupational Therapy _____
- 6) State Allocated FTE PT Positions Currently Filled _____ OT Positions _____
- 7) State Allocated FTE PT Positions Currently Vacant _____ OT Positions _____
- 8) Date of last State Caseload Review ____/____/____

Please attach the following to this form:

- A) A list of all MTUs and their corresponding satellites in the county. Include address and phone number for each.
- B) Copy of most current caseload review letter from the State.

Chief Therapist/Unit Supervisor

CCS Administrator

